

ACHA 2023 Sexual Health Services Survey Survey Report

Revised March 13, 2025



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Introduction and History

The American College Health Association (ACHA) has collected data from SHSs regarding STI/HIV surveillance, cervical cancer screening practices and management of abnormal results on a calendar year (CY) basis since 1991. Formerly known as the Pap Test and STI Survey, the purpose of the Sexual Health Services Survey (SHSS) is to provide benchmarking data on practices and STI/HIV testing outcomes for comparison among SHSs and analysis of trends over time. Previous reports can be found on the [Sexual Health Services Survey page](#) on ACHA's website.

To capture data from those institutions that engage in sexual health promotion but offer limited or no clinical services, a question regarding scope of sexual health services provided was added beginning with the CY 2018 & 2019 surveys. Changes were made to the survey again starting in CY 2020 to streamline data analysis and to reflect changes in guidelines and best practices.

As was announced during the CY 2020 survey cycle (the cycle of this report), there are now two versions of the survey that are distributed on alternating years. Here is a general breakdown of what is included in each version:

Both Even and Odd Years:

- Surveillance Questions
 - Cervical cancer screening outcomes
 - STI/HIV testing positivity
 - Pregnancy testing positivity

Even Years:

- Surveillance Questions
- General Practice Questions
 - Management of cervical cancer screening results
 - STI/HIV testing practices and services
 - Cost of STI/HIV testing
 - Extragenital testing
 - STI/HIV testing outreach events
 - Anonymous HIV testing
 - Routine chlamydia testing among patients assigned female at birth
 - Contraception provision
 - Services provided after positive pregnancy tests

Odd Years:

- Surveillance Questions
- Organizational assessment in alignment with the [Implementation Guide for Best Sexual Health Practices in College Settings developed by the American College Health Foundation](#)

Methods

This report contains data collected by ACHA Member Institutions for Calendar Year 2023 (January 1 - December 31) according to the Odd Years version of the SHSS.

Survey questions were written and edited by members of the ACHA Sexual Health Coalition with assistance from ACHA staff members. The survey was administered using Qualtrics Research Suite online survey software (Qualtrics, Inc.), and response data were analyzed using IBM SPSS Statistics v29 (SPSS, Inc.). The response period was December 2023 to May 2024.

Each Representative of the Member Institution (RMI) was emailed a unique survey link. The RMI was asked to either complete the survey or forward the survey link to the appropriate staff member for completion. Non-responders were sent reminder emails throughout the response period.

ACHA Institutional Members were asked to participate in the survey, and non-member institutions were also welcome to participate. We did not receive any submissions from non-member institutions. Therefore, the results of this survey may not be representative of all SHSs in the United States and extrapolation of these data to college populations in general may not be appropriate.

For calculations of test result positivity in variables with numerical data, we excluded respondents that did not provide both a numerator and a denominator in their response (i.e., the number of positive tests and the number of total tests performed, respectively). All percentages reported reflect valid percentages. The data were reviewed for data entry errors as well (e.g., if there were more positive results than total number of tests performed); those responses were excluded from analysis.

A Note about Gender Identity Data Collection

Not all laboratories and electronic health record systems (EHRs) collect and report gender identity data according to best practices that recognize and affirm trans and non-binary people^{1†}. Past versions of the survey have attempted to better capture gender identity data by including “transgender” or “trans and non-binary” to the sex assigned at birth clinical number breakdowns. While this was an important inclusion, transgender and non-binary gender identities are not mutually exclusive from sex assigned at birth, meaning data collection was less accurate and did little to help us understand the needs and experiences of the trans and non-binary communities. In an attempt to meaningfully shift our data collection to accurately reflect gender identity and set the expectation that schools should be reporting on gender identity and not just sex assigned at birth, we removed the breakdown of clinical numbers by sex and gender identity. In lieu of collecting this data during CY 2022, a question was added asking participating institutions if they were able to break down their clinical test numbers by gender identity on future versions of the survey and this was continued in CY 2023. Only 60% of participating institutions currently have the ability to disaggregate their data based on gender identity. We know that there is still a lot of work to be done on this front and are actively working to find more accurate and meaningful ways to capture this data. We call on all participating institutions to invest time and effort into collecting data in a way that allows it to be disaggregated based on gender identity.

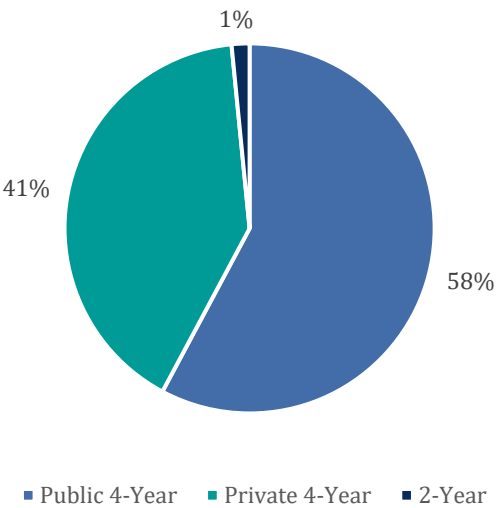
¹ †Collecting and reporting gender identity data is separate and distinctly different from collecting sex assigned at birth. According to ACHA's January 2020 Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings document, it is recommended to collect this data "in electronic health records (EHR) and other public health systems (i.e., needs assessments, program evaluations, infectious disease reports)". Specifically, collecting gender identity data "should be a two-step process, where the patient is first asked their gender identity followed by their sex assigned at birth".

Findings

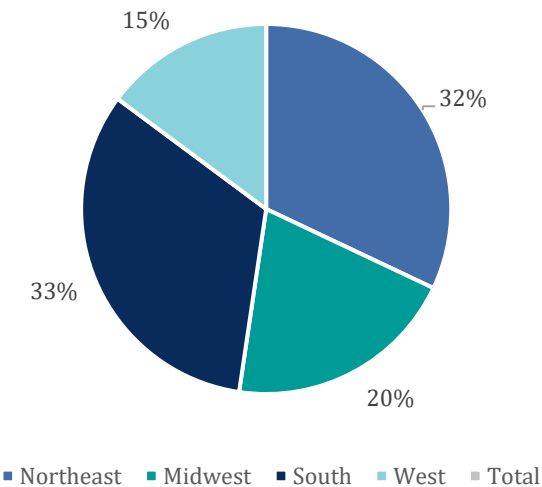
Demographics

Over the past several years, the number of participating institutions has ranged from a record high of 209 in CY 2022 to a low of 113 in CY 2017. A total of 134 schools completed the survey for CY 2023. The response rate was 17.7%. Of these schools, 128 (95.5%) provided clinical sexual health services at their student health center and were able to provide data for the survey. The majority of participating institutions were public, 4-year schools (57.8%) and schools with student populations of at least 10,000 (60.0%). All were institutional members of ACHA. This data is consistent when compared to 2021 and 2022 reports.

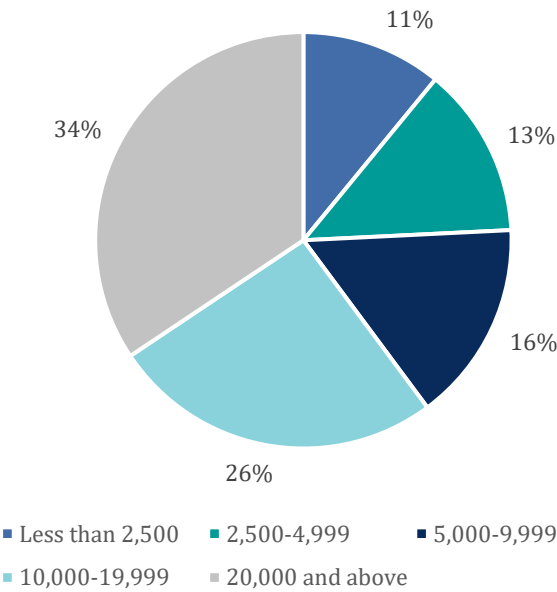
Type of Institution (N=128)



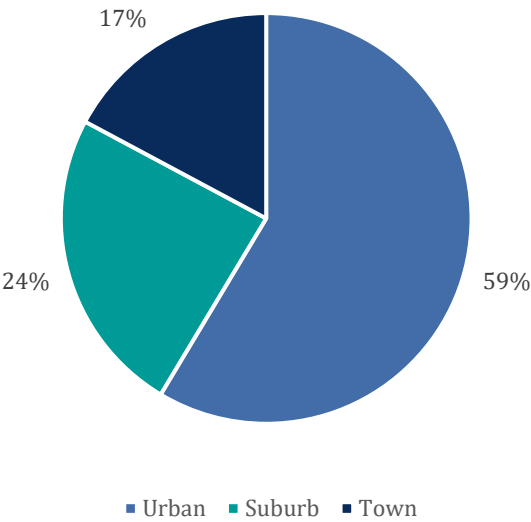
Region Per CDC/HHS (N=128)



Institution Size (N=128)



Campus Setting (N=128)



Clinical Data Disaggregation

In calendar year (CY) 2021, ACHA sought to better understand the clinical data disaggregation capabilities of electronic health records (EHR) used by participating institutions to identify gaps in sexual health services. Specifically, they focused on the ability to disaggregate data by sex assigned at birth, gender identity, race/ethnicity, and sexual orientation. This information collection continued in CY 2023. The most commonly used EHRs in CY 2023 were Medica (32.1%), Point and Click Solutions (31.3%), and PyraMED (11.2%). All other EHRs were used by less than 10% of the responding institutions.

From 2022 to 2023, the percentage of institutions capable of disaggregating data has continued to rise (Table 1). Despite this increase in capability, many institutions that have the ability to generate reports (Table 2) do not actually do so (Table 3). This trend is particularly noticeable with data on gender identity and sexual orientation.

Table 1

Ability to disaggregate data based on:	2022 Valid Percentage	2023 Valid Percentage
Assigned sex	83.1%	90.3%
Gender identity	60.2%	81.3%
Race/ethnicity	77.4%	88.5%
Sexual orientation	41.4%	52.1%

Table 2

Ability to run reports based on:	2022 Valid Percentage	2023 Valid Percentage
Assigned sex	83.1%	80.8%
Gender identity	60.2%	60.0%
Race/ethnicity	77.4%	77.8%
Sexual orientation	41.4%	40.7%

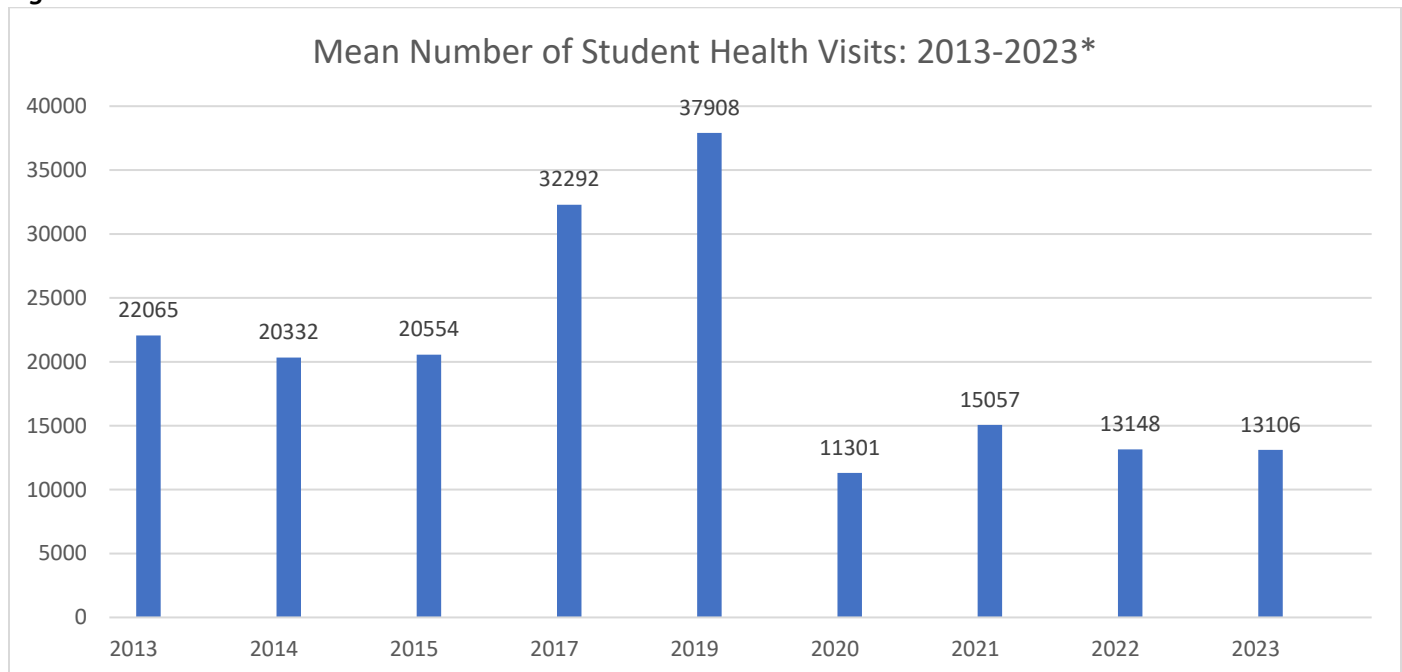
Table 3

Runs reports based on the following categories:	2022 Valid Percentage	2023 Valid Percentage
Assigned sex	55.6%	55.1%
Gender identity	31.1%	28.4%
Race/ethnicity	47.5%	49.2%
Sexual orientation	17.3%	16.4%

Clinic Utilization

This report represents sexual health data collected from within more than 1.5 million medical visits at student health services. This number continues to be notably less than pre-Covid 19 pandemic years. Telehealth visits make up 8% of these medical appointments. The mean number of student visits per calendar year are depicted in figure 1.

Figure 1



*CY 2016 and CY 2018 are not reflected in this graph because this data was not collected during those survey cycles.

Provision of Clinical Sexual Health Services

While nearly all responding institutions offering clinical sexual health services (N=128) responded that they offered pregnancy testing (98.4%), STI/HIV screening (93.8%), and contraception (92.2%), a little more than half offered PrEP (64.1%) and PEP (53.1%). Additionally, only 59.4% of responding institutions offered HPV vaccines in CY 2023. See figures 2-4.

Figure 2

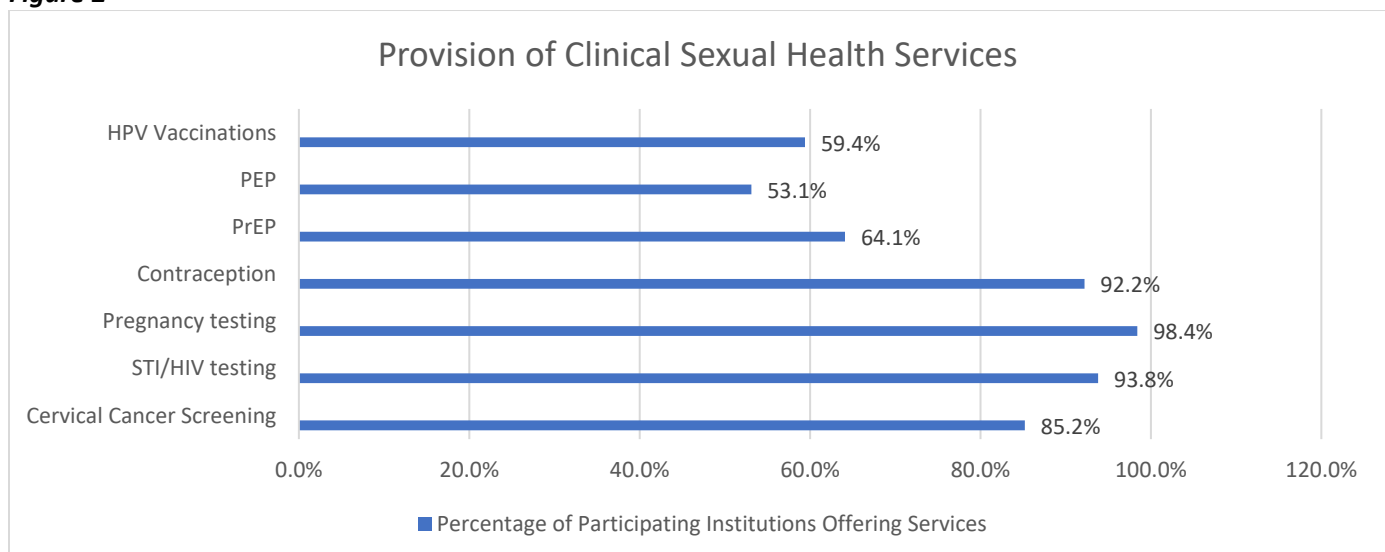
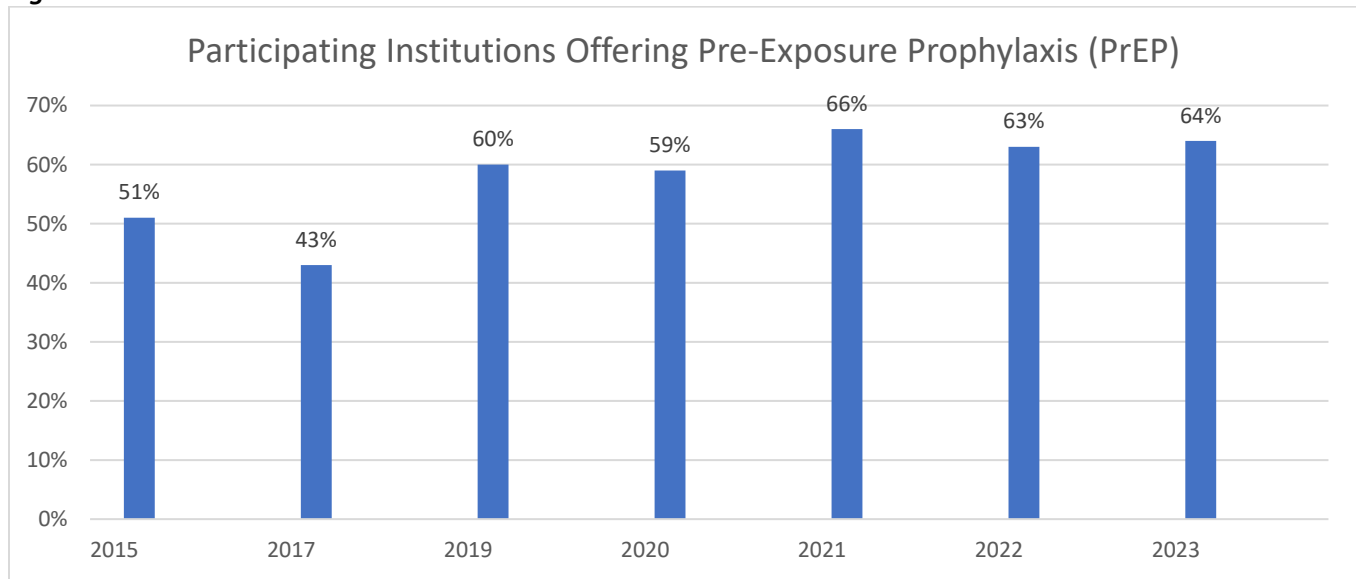
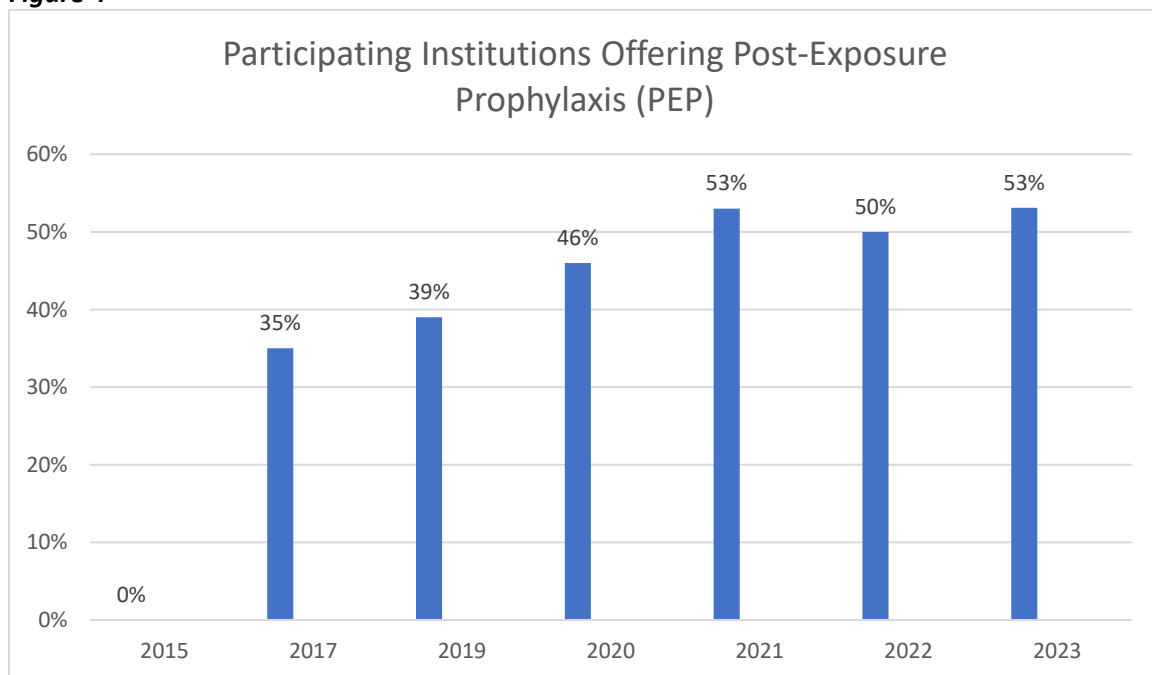


Figure 3



**CY 2106 and CY 2018 are not reflected on this graph because this data was not collected during those survey cycles.*

Figure 4



**CY 2106 and CY 2018 are not reflected on this graph because this data was not collected during those survey cycles.*

Surveillance Questions

Cervical Cancer Screening Outcomes

- Compared to CY 2022, there was a 42% decrease in the number of Pap tests (18,478) performed by participating institutions, 85.5% results were normal. This decrease in testing partially due to the number of schools participating.
- Of those that came back abnormal, the majority were atypical squamous cells of undetermined significance (6.9%) or low-grade squamous intraepithelial lesions (4.4%) (Table 4).

Pap Test Result	Meaning/Significance
Normal/Negative	No intraepithelial lesion or malignancy
Atypical Squamous Cells of Undetermined Significance (ASC-US)	Unclear or inconclusive. Some cells don't look completely normal, but the reason is unclear. May be related to HPV infection, yeast infection, polyps or hormone changes.
Low-Grade Squamous Intraepithelial Lesions (LSIL)	Low-grade changes that are usually caused by infection with HPV.
High-Grade Squamous Intraepithelial Lesions (HSIL)	Abnormal squamous cells (cervical cells) that could become cancerous in the future if not treated.
Atypical Squamous Cells, cannot exclude HSIL (ASC-H)	Some abnormal squamous cells that may become HSIL, but uncertain.
Atypical Glandular Cells (AGC)	Glandular cells that do not look normal; could signal problems inside the uterus.
Adenocarcinoma in situ (AIS) or (CIS)	Area of abnormal growth in glandular tissue of cervix; pre-cancer and may become cancer if not treated.

Table 4- CY 2023 Summary of all Pap test results

	Frequency	Percent
Total # of Pap tests done (n=109)	18,478	
Normal (n=109)	15,802	85.5%
ASC-US (n=109)	1,282	6.9%
LSIL (n=109)	822	4.4%
ASC-H (n=109)	74	0.4%
HSIL (n=109)	32	0.2%
ACG or CIS (n=109)	22	0.1%
Unsatisfactory, no dx (n=109)	271	1.5%
other dx, not listed above (n=109)	173	0.9%
no endocervical cells (with any dx above) (n=73)	920	5.0%

STI/HIV testing positivity

- Out of all patients assigned female at birth and under age 25, only 16.2% were tested for chlamydia. However, the positivity rate for chlamydia declined from 6.38% in CY 2022 to 5.58% in CY 2023.
- Unlike previous years, in CY2023 there was an attempt to gather site specific data for chlamydia and gonorrhea site specific positivity (Table 5). It should be noted that cervical site testing was grouped with vaginal swab data. Future surveys should include cervical screening as a separate anatomical site.

- Positivity rates for Human Immunodeficiency Virus (HIV) and Syphilis have remained stable over the last decade, with HIV rates ranging from 0.1% to 0.3%. In CY2023 the positivity rate was 0.22%.
- Syphilis rates nationwide continue to be on the rise. As shown in Figure 5, positivity rates for Syphilis have steadily increased in the last ten years, however in 2023 there was an 11.4% decrease from CY 2022 to CY2023 in the percentage of positive syphilis cases.
- Of the patients who tested positive for Herpes Simplex Virus (HSV), the majority (65.6%) continue to be HSV-1.
- In CY 2023, there were 209 cases of trichomoniasis diagnosed at 107 schools, 9,326 cases of bacterial vaginosis diagnosed at 100 schools, and 415 cases of genital warts diagnosed at 89 schools.
- A majority of reporting institutions (63.6%) provide EPT at provider discretion. Only 5.1% provide EPT as clinic policy and 2.5% report that EPT is not legal in their states.
 - In CY 2023 questions were added to better understand the challenges of EPT on college campuses. While some respondents expressed no challenges/concerns about offering EPT, others reported concerns over offering EPT to non-student partners whose medical history is unknown.

Figure 5

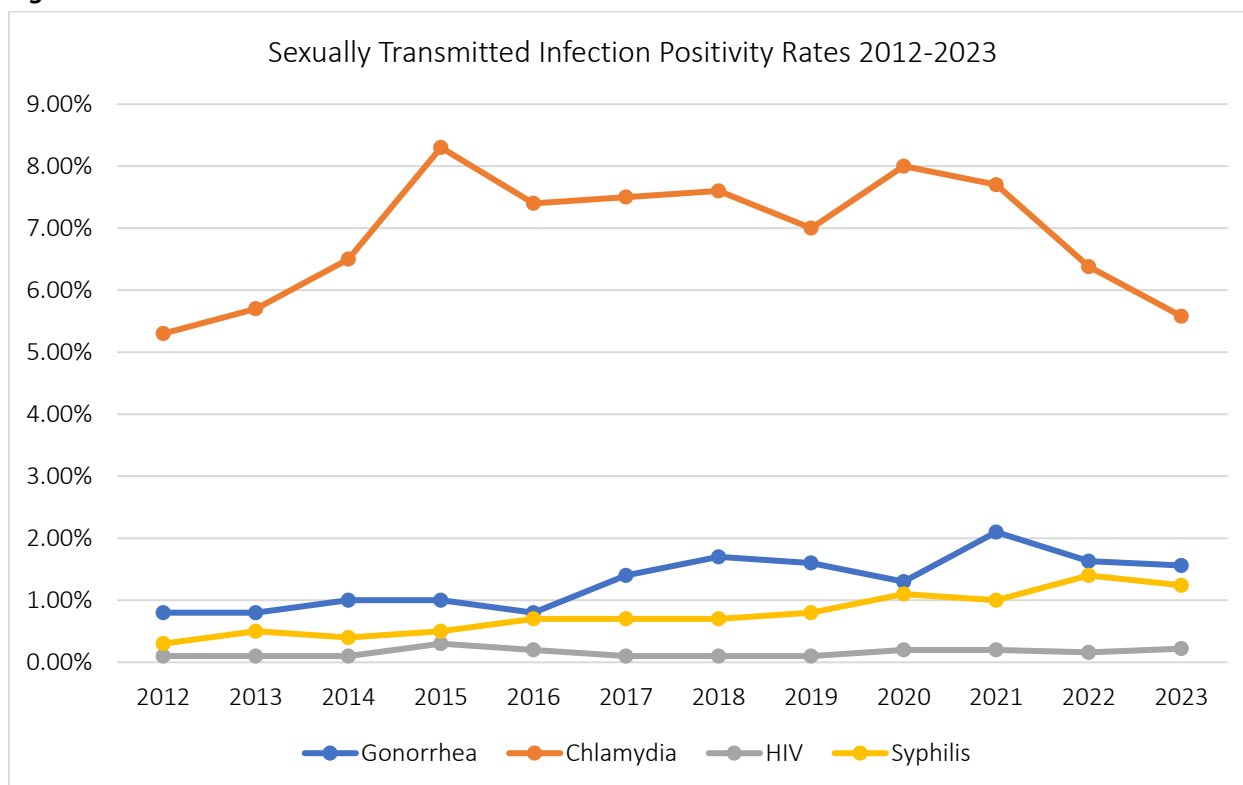
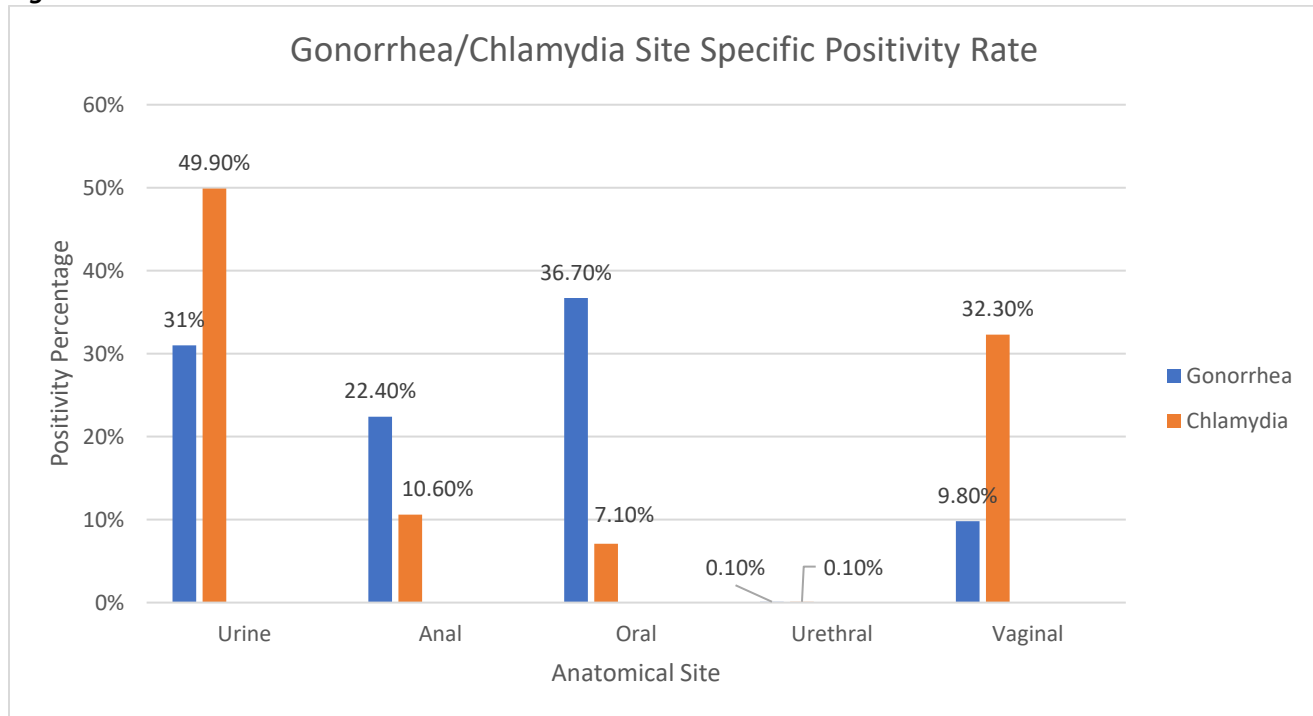


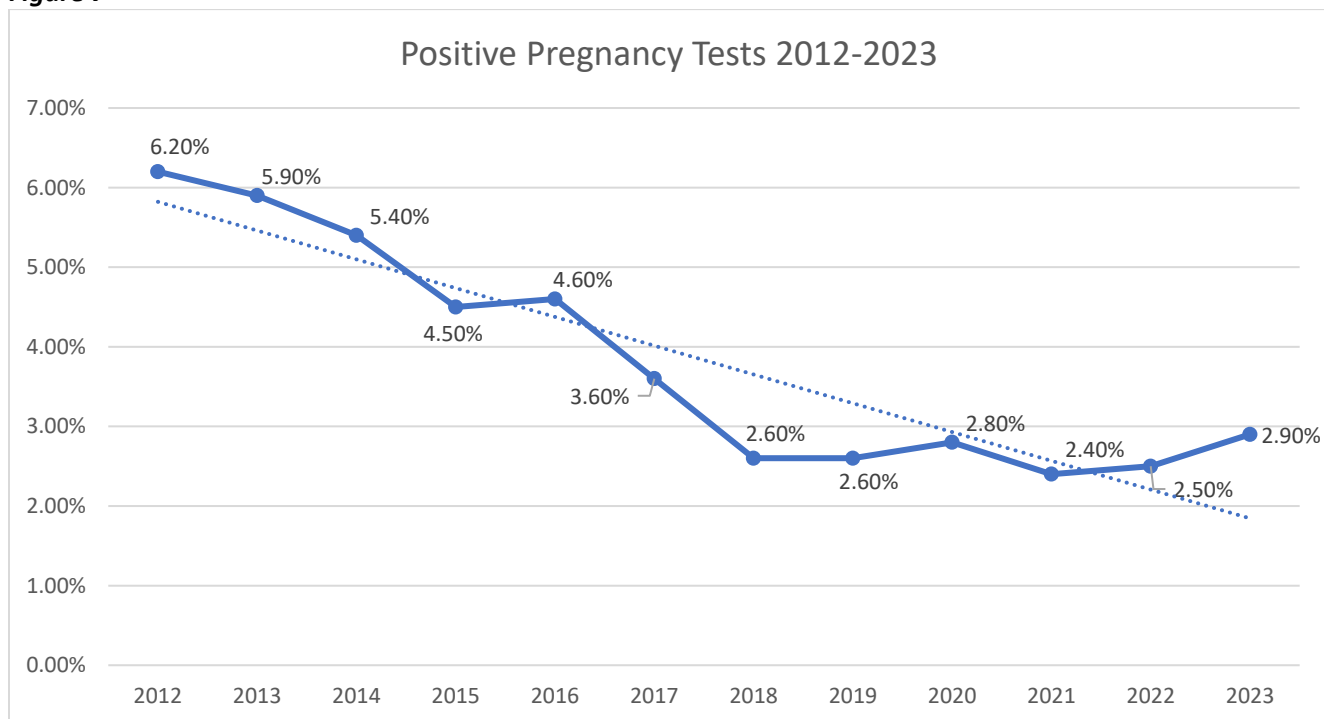
Figure 6



Pregnancy testing positivity

A total of 33,239 pregnancy tests were performed by participating institutions in CY 2023 with a 2.9% positivity rate. Compared to 2022 data, this is an increase in positive tests by 16% (Figure 7) and an overall increase since 2021.

Figure 7



Best Practices Questions:

In accordance with [ACHA's Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings white paper](#), published in January 2020, the SHSS for CY 2023 asked participating universities to assess their health center's progress in implementing best practices.

Do not intend to implement	Your health center does not intend to implement the best practice. Reasons may include issues related to legality, policy, lack of buy-in, resources, staffing, etc.
Intend to implement, but have not yet begun	Your health center is able to implement the best practice and intends to do so, but has not yet begun the process due to various constraints. For example, a best practice may be part of an organization's strategic plan but will not be addressed until the end of the current planning cycle.
Implementation in progress	Your health center has begun the process of implementing the best practice (e.g., a meeting has happened to move it forward, policies are currently being drafted, etc.).
Implemented & maintaining	Your health center has implemented the best practice, and is actively working to maintain it (e.g., regular staff trainings, budget line item, ongoing evaluation, etc.).

Incorporate Pleasure and Intimacy into Sexual Health Efforts

Pleasure and sexual satisfaction are important aspects of healthy and fulfilling sexual activity. Only 13% of responding institutions' EHR templates and/or patient questionnaires captures data regarding sexual pleasure and satisfaction during wellness visits (Table 5, 1) and 38.3% of institutions' health education programs include information about pleasure and sexual satisfaction (Table 5, 3). A majority of institutions (77.7%) provide safer sex supplies with a variety of options, styles, and sizes, including lubricant (Table 5, 4).

Table 5

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
EHR templates and/or patient questionnaires used during routine wellness visits include questions about sexual pleasure and satisfaction.	70	53.4%	41	31.3%	3	2.3%	17	13.0%



EHR templates and/or patient questionnaires used during problem-focused visits for sexual health include questions about pleasure and sexual satisfaction.	67	51.5%	44	33.8%	3	2.3%	16	12.3%
Health education programs include information about pleasure and sexual satisfaction.	43	33.6%	20	15.6%	16	12.5%	49	38.3%
Any office providing safer sex supplies provides a variety of options, styles, and sizes, including lubricant.	17	13.1%	2	1.5%	10	7.7%	101	77.7%



Create a Welcoming Clinic Environment and Provide Inclusive Resources and Services

Since 2021 there has been a noticeable increase in inclusion and positive sexual health messaging on college campuses. In CY 2023, 43% of responding institutions reported have a website with sex-positive/inclusive language. This is an 18% increase from CY 2021. Over half require inclusivity training (57.4%) and have a strategic commitment to diverse representations (60.9%) (Table 6, 1, 3-4).

Table 6

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Website has sex-positive messages with same- and different-gender partners, as well as people of different ethnicities, races, gender expressions and physical abilities.	26	20.3%	31	24.2%	16	12.5%	55	43.0%



Posters, brochures and other materials have sex-positive messages with same- and different-gender partners, as well as people of different ethnicities, gender expressions and physical abilities.	13	10.0%	19	14.6%	21	16.2%	77	59.2%
Staff are required to receive training on LGBTQIA+ inclusivity. Training should include informing patients of the confidentiality of sexual orientation and gender identity (SOGI) data.	12	9.3%	18	14.0%	25	19.4%	74	57.4%
Strategic planning or goal setting includes ensuring staff are diverse and represent the communities they serve.	6	4.7%	15	11.7%	29	22.7%	78	60.9%



Considerations for Trans and Non-Binary Students

Supporting trans and non-binary students requires advocating for change on the individual, group, and policy levels. While almost 90% (87.8%) of responding institutions have gender-inclusive bathrooms, over half (53.1%) do not intend to have clinicians provide gender-affirming hormone therapy for trans and non-binary students (Table 7, 2-4)

Table 7

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
Policy is in place regarding appropriate staff interactions with trans and non-binary students.	20	15.4%	24	18.5%	17	13.1%	69	53.1%



Clinicians provide gender-affirming hormone therapy for trans and non-binary students.	69	53.1%	14	10.8%	6	4.6%	41	31.5%
Student health insurance policy explicitly covers services related to transgender care.	46	37.7%	8	6.6%	4	3.3%	64	52.5%
Gender-inclusive restrooms are available and accessible.	9	6.9%	3	2.3%	4	3.1%	115	87.8%



Collect Sexual Orientation and Gender Identity (SOGI) Data

Accurately and meaningfully collecting SOGI data is an important step toward health equity as it allows student health centers to identify and address health disparities. More than 85% responding institutions were intending to implement, in the process or implementing, or successfully implementing all three SOGI data items (Table 8, 1-3).

Table 8

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
EHR templates and/or patient questionnaires include specific field for name the student would like to be called (i.e., lived name), and this field is not referred to as a “preferred name.”	19	14.5%	21	16.0%	12	9.2%	79	60.3%
EHR templates and/or patient questionnaires include specific field for student’s pronouns, and this field is not referred to as “preferred pronouns.” An open-ended “other” option	14	10.7%	21	16.0%	14	10.7%	82	62.6%



is also available.								
EHR templates and/or patient questionnaires include specific fields for gender identity in a two-step process, where student is first asked about gender identity and then their sex assigned at birth. Open-ended “other” options are available.	17	13.2%	25	19.4%	15	11.6%	72	55.8%
EHR templates and/or patient questionnaires include specific field with options for sexual orientation, and this field is not referred to as a “sexual preference.” An open ended “other” option is available.	19	14.5%	23	17.6%	17	13.0%	72	55.0%



Use a Trauma-Informed Approach to Sexual Health Promotion and Clinical Care

Implementing trauma-informed practices during sexual health activities requires a commitment to doing so and subsequent strategic planning. However, nearly 24% participating institutions do not intend to infuse trauma-informed approaches into their mission statements or strategic planning activities (11.4%) (Table 9, 1-2). Conversely, health education and promotion efforts at over half of responding institutions infused a number of trauma-informed approaches in their events and activities (Table 9, 7-9).

Table 9

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
The mission statement for the department or program requires that services are trauma informed.	28	23.9%	47	40.2%	6	5.1%	36	30.8%



Strategic planning or goal setting requires that services are trauma-informed.	21	17.2%	43	35.2%	10	8.2%	48	39.3%
Policies or procedures are in place requiring clinicians to obtain patient histories while patients are clothed.	14	11.4%	20	16.3%	8	6.5%	81	65.9%
Policies or procedures are in place to allow the presence of a support person for the patient during a clinical encounter.	9	7.2%	12	9.6%	10	8.0%	94	75.2%
Policies or procedures are in place requiring clinicians to inform the patient that the patient is in control and is able to stop any clinical encounter at any time.	9	7.1%	15	11.9%	11	8.7%	91	72.2%
Policies or procedures are in place requiring clinicians to use language patient uses for their own anatomy throughout the clinical encounter. EHR templates and/or patient questionnaires reflect this requirement.	27	22.7%	31	26.1%	9	7.6%	52	43.7%
Health education programs always inform the audience of upcoming content -- sometimes called giving a trigger	16	12.9%	16	12.9%	18	14.5%	74	59.7%



warning -- to empower participants to choose whether or not to engage with the material.								
Health education programs always affirm at the beginning that participants are free to leave for any reason at any time during the program to take care of themselves.	13	10.7%	12	9.8%	15	12.3%	82	67.2%
Health education programs relevant to sexual health always set an expectation that participants will use inclusive language and honor participants' use of terms to describe themselves and their bodies.	14	11.3%	10	8.1%	14	11.3%	86	69.4%
Staff are required to be trained in trauma-informed practice.	14	11.5%	46	37.7%	15	12.3%	47	38.5%



Address Confidentiality Concerns

Confidentiality is often a concern for students, especially when it comes to sexual health care. As such, the vast majority of participating institutions are successfully implementing several confidentiality-related best practices (Table 10, 1-4).

Table 10

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Policy is in place protecting patient confidentiality to the maximum extent permitted by state law (e.g., explanation of benefits [EOB] is sent to patient, not policyholder).	9	7.0%	9	7.0%	5	3.9%	106	82.2%
Website, EHR templates and/or patient questionnaires inform patients of the ways in which their health information is kept private and/or confidential, as well as any circumstances when information may be disclosed (e.g., Clery Reporting, Title IX). Patients are also informed that they do not have to answer any questions they do not want to answer when receiving services.	3	2.4%	13	10.2%	4	3.1%	107	84.3%
Sexual health services are provided at low or no cost for patients who do not wish to bill their insurance for these	19	14.7%	13	10.1%	5	3.9%	92	71.3%



services.								
Patient bills or account charges list services generically (e.g., “Student Health Center Fee” instead of “Birth Control Visit”).	18	15.0%	8	6.7%	3	2.5%	91	75.8%
Online student health portal explicitly encourages students to have different passwords than ones used for other university accounts, and to avoid sharing those passwords with anyone.	53	42.4%	19	15.2%	1	0.8%	52	41.6%



Make Referrals Appropriate

Most participating institutions are successfully taking steps to make appropriate referrals (Table 11).

Table 11

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Organization maintains a referral list for sexuality professionals on campus and in the broader community.	9	7.0%	17	13.2%	17	13.2%	86	66.7%
Policies and procedures are in place to refer a student and/or patient who discloses sexual or relationship violence to services not provided in-house (e.g., mental health services, academic	2	1.5%	6	4.6%	7	5.4%	115	88.5%



accommodations, etc.)								
Policies or procedures are in place regarding reporting of student and/or patient disclosures of sexual or relationship violence to institution's Title IX and/or non-discrimination office (if required).	0	0.0%	6	4.7%	2	1.6%	121	93.8%
Policies and procedures are in place to refer a trans patient to any gender-affirming care not provided in-house.	9	7.0%	20	15.6%	6	4.7%	93	72.7%
Policies and procedures are in place for linking patients newly diagnosed with HIV to comprehensive medical and mental health care, including referral to Partner Services/Disease Intervention Specialists.	6	4.6%	14	10.8%	7	5.4%	103	79.2%
Policies and procedures are in place to direct clinical staff to refer patients to specialists for complicated STI diagnoses.	6	4.7%	10	7.8%	4	3.1%	109	84.5%



Evaluate Your Efforts

Evaluation is critical to understand what sexual health care and practices are effective and what needs additional thought and attention. Efforts to evaluate are mixed across institutions, for example, over 70% analyze and use data (quantitative and qualitative) to evaluate and improve services and programming, but only 41.6% disaggregate clinical data to identify health disparities (Table 12, 1-4).

Table 12

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Quantitative data are collected, analyzed and used to evaluate and improve services and programming at least once per year.	4	3.1%	17	13.0%	16	12.2%	94	71.8%
Qualitative data are collected, analyzed and used to evaluate and improve services and programming at least once per year.	6	4.6%	21	16.2%	12	9.2%	91	70.0%
Qualitative and quantitative data collection and analysis is disaggregated to identify and address health disparities for different populations (i.e., by race, ethnicity, sexual orientation, gender identity, first generation status, etc.).	12	9.6%	42	33.6%	19	15.2%	52	41.6%
Qualitative and quantitative data collection and analysis include examination of utilization rates for sexual health services by different	17	13.7%	54	43.5%	12	9.7%	41	33.1%



populations.								
A summary of evaluation efforts and responses made to improve services and programming is shared with community stakeholders at least once per year.	12	9.8%	31	25.2%	12	9.8%	68	55.3%



Use the Socioecological Model to Improve Sexual Health

On average 78% of institutions are successfully utilizing the socioecological model to guide efforts to improve sexual health and sexual health services (Table 13, 1-4).

Table 13

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Interventions emphasize primary prevention.	4	3.1%	6	4.7%	8	6.2%	111	86.0%
Interventions focus on campus life and the many environments in which students live, work and play.	6	4.6%	6	4.6%	16	12.3%	102	78.5%
Interventions address individual, interpersonal, organizational, community and societal levels.	5	3.9%	7	5.4%	21	16.3%	96	74.4%
Interventions are designed in partnership with the student community.	4	3.1%	10	7.8%	20	15.6%	94	73.4%



Implement and Inclusive, Evidence-Based Availability Program for Safer Sex Products

Across all measures, over half of responding institutions are implementing and maintaining inclusive, evidence-based availability programs for safer sex products, this includes providing a diverse range of safer sex products like condoms, dental dams, and lube (Table 14, 1-11). However, many items also had a large percentage of schools with no intention to make these products available (Table 14, 5-10).

Table 14

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Safer sex supplies are available to students free of charge.	11	8.3%	1	0.8%	0	0.0%	120	90.9%
Safer sex supplies are located in multiple spaces that are accessible to a variety of students.	14	10.6%	5	3.8%	2	1.5%	111	84.1%
Safer sex product program is publicized to students (e.g., through social media, websites, posters in student spaces, etc.)	17	12.9%	7	5.3%	5	3.8%	103	78.0%
Non-latex safer sex supplies are available.	20	15.3%	5	3.8%	3	2.3%	103	78.6%
Dental dams are available.	21	16.3%	9	7.0%	4	3.1%	95	73.6%
External condoms are available.	14	10.6%	1	0.8%	0	0.0%	117	88.6%
Internal condoms are available.	18	14.1%	8	6.3%	5	3.9%	97	75.8%



Non-lubricated condoms are available.	32	24.8%	8	6.2%	2	1.6%	87	67.4%
Latex and/or nitrile gloves are available in multiple sizes.	47	36.4%	11	8.5%	2	1.6%	69	53.5%
Water-based lubricant is available.	21	16.0%	7	5.3%	2	1.5%	101	77.1%
Silicone-based lubricant is available.	47	36.4%	11	8.5%	3	2.3%	68	52.7%



Leverage Social Media

Social media is a powerful tool to disseminate health information and is widely used by the college-aged population, meaning successful utilization of social media is vital to promoting evidence-based health practices. Sixty-six percent of institutions use social media to provide positive messaging around sexual health. Conversely, one-third of reporting institutions have not begun implementing any of the social media best practices described in Table 15.

Table 15

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Social media is used to provide positive, engaging messaging about sexual health.	13	10.2%	19	14.8%	11	8.6%	85	66.4%
Social media metrics (e.g., impressions, shares, reach, etc.) are analyzed to assess effectiveness of content and measure engagement.	16	12.8%	25	20.0%	20	16.0%	64	51.2%



Social media content is created in consultation with students to amplify their voices regarding sexual health.	13	10.4%	25	20.0%	16	12.8%	71	56.8%
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Be Proactive about Sexual Health with All Patients and Take an Inclusive, Comprehensive Routine Sexual History

The majority of institutions reported conversations and EHR templates to discuss and record information about sexual health, however, only 40.3% report the use of the “8 Ps approach” to obtain sexual history (Table 16, 1-4).

Table 16

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Clinicians engage patients in conversations about sexual health, as appropriate, during preventive visits -- not just during problem-focused sexual health visits.	6	4.6%	6	4.6%	10	7.6%	109	83.2%
EHR templates and/or patient questionnaires use the “8 Ps approach” to obtain sexual history (i.e., Preferences, Partners, Practices, Protection from STIs/HIV, Past History of STIs, Pregnancy, Pleasure, and Partner Violence).	28	21.7%	30	23.3%	19	14.7%	52	40.3%
EHR templates and/or patient questionnaires on sexual history use open-ended	6	4.7%	15	11.6%	12	9.3%	96	74.4%



questions with nonjudgmental tone and demeanor.								
EHR templates and/or patient questionnaires include specific field for an organ inventory to guide screening and management of specific complaints for trans and non-binary patients.	31	24.6%	49	38.9%	8	6.3%	38	30.2%



Assess Patients' Reproductive Goals

Almost half of institutions that responded do not intend to implement EHR templates/patient questionnaires that address patient's reproductive goals (Table 17, 1).

Table 17

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
EHR templates and/or patient questionnaires include field for patient's reproductive goals for the next year.	60	46.9%	40	31.3%	6	4.7%	22	17.2%
EHR templates and/or patient questionnaires direct clinicians to counsel students desiring pregnancy or not using reliable forms of contraception or who are otherwise capable of pregnancy (i.e., transmasculine students having penis-vagina sex) to take a supplement	46	36.5%	34	27.0%	8	6.3%	38	30.2%



containing 0.4-0.8 mg of folic acid daily for the prevention of neural tube defects.								
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Assess for Trauma and Violence

Policies and EHR templates largely supported or are working toward supporting those impacted by trauma and violence (Table 18, 1-2).

Table 18

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
EHR templates and/or patient questionnaires screen patients for trauma and trauma symptoms using non-gendered language, in private, annually.	22	17.3%	41	32.3%	9	7.1%	55	43.3%
Policies and procedures are in place to provide patients who screen positive for trauma and trauma symptoms with ongoing support or referred to appropriate agencies.	14	11.1%	27	21.4%	7	5.6%	78	61.9%



Orient Clinical Care Toward Prevention

Just over 10% of responding institutions had no intention of implementing reminder EHR templates or other tools for testing, vaccination, and preventative care (Table 19).

Table 19

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
EHR templates, patient questionnaires, and/or other clinical decision support tools are used to remind clinicians of testing, vaccination, and other preventive care needs.	13	10.1%	23	17.8%	13	10.1%	80	62.0%



Vaccinations

Vaccination is a powerful public health tool to prevent the spread of infectious disease and illness. Responding institutions are actively doing work around vaccinations for HPV, HAV, and HBV with their students, including nearly half of institutions in each question already practicing and maintaining the best practice (Table 20).

Table 20

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
EHR templates and/or patient questionnaires for all patients age 45 years and younger include a question about human papillomavirus (HPV) vaccination status.	28	22.0%	30	23.6%	14	11.0%	55	43.3%



Policies and/or procedures are in place for clinicians to recommend HPV vaccine to all patients age 45 years and younger who are not fully vaccinated.	19	14.8%	25	19.5%	15	11.7%	69	53.9%
Policies and/or procedures are in place for clinicians to recommend vaccination against hepatitis A virus (HAV) for any patients who are men who have sex with men (MSM), who have not previously been vaccinated.	23	18.3%	33	26.2%	12	9.5%	58	46.0%
Policies and/or procedures are in place for clinicians to recommend vaccination for Hepatitis B virus (HBV) for patients not previously vaccinated, patients at risk for HBV infection (i.e., through sexual exposure) or patients requesting protection from HBV without a specific risk factor.	15	11.5%	30	23.1%	8	6.2%	77	59.2%



Cervical Cancer Screening

On average, 79% of participating institutions are implementing and maintaining best practices across all cervical cancer screening measures (Table 21).

Table 21

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Policies and/or procedures are in place for clinicians to recommend screening for cervical cancer (via Pap test) for all patients with a cervix based on current national guidelines, regardless of sexual activity.	10	7.7%	11	8.5%	6	4.6%	103	79.2%
Policies and/or procedures are in place for clinicians to decide whether to perform a pelvic exam based on medical history or symptoms, in partnership with the patient.	14	10.7%	9	6.9%	4	3.1%	104	79.4%
Policies and/or procedures are in place for clinicians to offer smaller-sized speculums during pelvic exams for patients who have never had penetrative vaginal sex, patients with a physical or psychological sensitivity, or if the patient expresses a	14	10.7%	11	8.4%	4	3.1%	102	77.9%



preference.								
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STI and HIV Screening

With over half of new STIs being in youth aged 15-24², STI and HIV screening in accordance with all recommendations is vital prevention work on a college campus. Below outlines best practices for STIs along with the percentage of institutions currently implementing them. Notably, only 51.2% of institutions have 4th generation rapid HIV Ab/Ag POC testing available and 38% do not intend to implement it (Table 22, 3).

Table 22

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Policies and/or procedures are in place to allow asymptomatic patients who have not had a known exposure to be screened for STIs/HIV without a provider visit.	30	23.3%	11	8.5%	5	3.9%	83	64.3%
Policies and/or procedures are in place to provide routine, opt-out HIV screening following recommendations published by the CDC.	35	27.3%	17	13.3%	5	3.9%	71	55.5%
4th-generation rapid HIV Ab/Ag POC testing is available.	49	38.0%	11	8.5%	3	2.3%	66	51.2%
Policies and procedures are in place to ensure an HIV test is offered when STI testing is requested, and STI testing is offered when HIV testing is requested.	12	9.1%	8	6.1%	7	5.3%	105	79.5%



Policies and/or procedures are in place for clinicians to screen for STIs at all appropriate anatomical sites, following recommendations published by the CDC and USPSTF, regardless of patient's sexual orientation or gender identity.	12	9.2%	10	7.6%	6	4.6%	103	78.6%
Policies and/or procedures are in place to permit patients to self-swab when possible, including oral and rectal samples, for self-motivated patients as indicated.	18	13.8%	11	8.5%	4	3.1%	97	74.6%



Implement Expedited Partner Therapy (EPT) Where Legal

EPT consists of supplying the sex partners of patients diagnosed with chlamydia or gonorrhea with medication without requiring a visit to a healthcare provider³. Due to the variability of laws between different states, EPT is not legal in every state, preventing responding institutions from implementing it. Just over a third of participating institutions have implemented each of the best practices listed below (Table 23).

Table 23

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
At least once per year, the legal status of EPT in the state is reviewed with staff.	42	33.3%	28	22.2%	11	8.7%	45	35.7%
If legal, policies and/or procedures are in place to require clinicians to offer EPT to students.	56	44.8%	22	17.6%	4	3.2%	43	34.4%



Offer Pre-Exposure Prophylaxis (PrEP) as Appropriate

Only 42% of SHSs have policies in place that require clinicians to prescribe PrEP while 37% do not intend to implement PrEP best practices (Table 24, 1). However, 63.6% do provide community resources for those patients eligible for PrEP (Table 24, 4).

Table 24

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Policies and/or procedures are in place to require clinicians to offer PrEP.	48	37.2%	19	14.7%	8	6.2%	54	41.9%
EHR templates and/or patient questionnaires used during routine wellness visits include questions about PrEP.	40	32.0%	35	28.0%	14	11.2%	36	28.8%
EHR templates and/or patient questionnaires used during PEP visit includes a question about PrEP, especially if the patient is in a sexual relationship with someone who is living with HIV.	44	35.5%	28	22.6%	9	7.3%	43	34.7%
Patients eligible for PrEP are provided with resources to navigate insurance and enhance access (i.e., patient assistance programs, community resources, etc.).	22	17.1%	16	12.4%	9	7.0%	82	63.6%



PrEP patients are sent reminders for follow-up appointments.	50	39.7%	27	21.4%	6	4.8%	43	34.1%
PrEP patients who miss their follow-up appointments are contacted to be rescheduled.	44	34.9%	31	24.6%	11	8.7%	40	31.7%



Offer Post-Exposure Prophylaxis (PEP) as Appropriate

PEP is an important responsive tool for those who are exposed or may have been exposed to HIV. However, more institutions do not intend to require clinicians to offer PEP (40.6%) than institutions who have implemented and are maintain offering PEP (35.9%) (Table 25).

Table 25

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
Policies and/or procedures are in place to require clinicians to offer PEP.	52	40.6%	20	15.6%	10	7.8%	46	35.9%



Recommended Action Steps Based on These Data

Best practice guidelines and other implementation resources for these recommendations can be found in the Resource section at the end of this document.

Working Toward Health Equity

- Periodically disaggregate all clinical data according to race, ethnicity, gender identity and sexual orientation to identify gaps in equitable access to screening and appropriate diagnosis and treatment.
 - Gaps may include:
 - HPV vaccination uptake
 - Rates of new STI/HIV infections
 - STI/HIV testing uptake
 - Contraception use
 - Access to screening, diagnosis, and treatment of cervical precancer or cancer in a timely fashion

Cervical Cancer Screening and Management

- Follow appropriate cervical cancer screening guidelines
 - Perform first screening at age 21
- Follow appropriate guidelines for management of abnormal cervical cancer screening results
 - Current guidelines for the management of a first screening Pap test reported as ASC-US (either without HPV results or positive HPV) in women under age 25 recommend repeating cytology in 12 months as the preferred practice for management¹
 - Place emphasis on personalized management based on the patient's risk of having or developing CIN 3+ and incorporate new test methods as they become available.
- Stay updated on current guidelines and use available technology to assist with decision-making

STI/HIV Prevention and Testing

Improving Access

- Advocate for coverage of STI/HIV testing via mandatory health fee or other fund to increase access and eliminate patient's need to navigate insurance -- especially if they are dependents
- Consider partnering with your local health department and/or AIDS service organization to provide free STI/HIV testing on campus on a regular basis
- Know where anonymous HIV testing is provided in the community (where legal) so that you can refer students who desire this service

Clinical Services

- Offer HPV vaccinations
- Screen all sexually active female patients under 25 for chlamydia annually
- Screen all appropriate anatomic sites for chlamydia and gonorrhea according to comprehensive sexual history, regardless of patient's gender identity
- Offer pre-exposure prophylaxis and post-exposure prophylaxis to reduce risk of HIV acquisition
- Offer expedited partner therapy (EPT) -- where legal -- to treat partner(s) and reduce risk of STI transmission
- Screen for HIV when screening for other STIs
- Provide routine, opt-out HIV testing in clinical settings

Reproductive Health

- Assess patients' reproductive goals to guide counseling and recommendations
- For those who do not desire pregnancy, begin contraceptive counseling by describing options in order of

effectiveness (i.e., from long-acting reversible contraceptives to withdrawal)

- Provide all-options counseling for those with a positive pregnancy test
- Increase provision of copper intrauterine devices (IUDs) as emergency contraception (EC) to provide the most effective option for students of any weight.
- Advocate for access to various forms of sexual and reproductive healthcare including education, counseling, testing for sexually transmitted infections and HIV, access to contraceptive options, emergency contraception, preconception counseling, pregnancy and postpartum care, and abortion.

Best Practices

- Advocate within the student health center to implement the guidance put forward in the [Implementation Guide for Best Sexual Health Practices in College Settings developed by the American College Health Foundation.](#)
- Add EHR templates that include questions about pleasure and sexual satisfaction.
- Provide gender-affirming hormone therapy to trans and non-binary students.
- Infuse a commitment to trauma-informed practices into health center mission statements and strategic planning.
- Analyze clinical data to identify health disparities and determine strategic priorities and actionable goals.
- Diversify safer sexual health supplies, including offering nitrile gloves, dental dams, and both water-based and silicone-based lubricants.
- Continue to utilize social media to disseminate inclusive, medically accurate, and comprehensive sexual health information.
- Expand EHR templates to be gender-inclusive and collect information that supports the care of trans and non-binary students.
- Require clinicians to offer PrEP and PEP to all students.
- Advocate for all areas of reproductive health.

Limitations

- The sample consists of only ACHA member institutions and may not be generalizable to all college health centers.
- The data in this report was collected for CY 2023, and the difference in some numbers (such as marked increase of clinic visits and pap tests) could reflect the transition out of the COVID-19 pandemic. The survey also did not differentiate between telehealth and in-person visits. As previously mentioned, the offering of telehealth visits is also a likely outcome of the pandemic. While this option may increase access for some students, this makes it difficult to compare results with previous surveys.
- In an attempt to gather data regarding extragenital/site specific testing, survey questions grouped cervical testing with vaginal testing and may not provide an accurate representation of results.
- Caution should be used when comparing Sexual Health Services Survey figures between data collection periods. Participating institutions change from year to year and any differences observed may be attributed to changes in the sample and not a true change in experience at the same clinics.

Resources

ACHA Resources:

- [Best Practices in Sexual Health Promotion and Clinical Care in College Health Settings.](#)
- [Implementation Guide for Best Sexual Health Practices in College Setting](#)
- [HIV Pre-Exposure Prophylaxis Guidelines](#)
- [The State of Sexual Health on College Campus](#)
- [SHSS reports from previous years](#)
- Webinars from the American College Health Foundation and Hologic, Inc.:
 - [\(Re\)Introducing Best Practices in Sexual Health Promotion & Clinical Care in the COVID-19 Era \(September 25, 2020\)](#)
 - [Case Studies: Best Practices in Sexual Health Promotion & Clinical Care in College Health Settings \(November 13, 2020\)](#)

Other Resources:

- [United States Preventive Services Task Force \(USPSTF\), 2022. Cervical Cancer: Screening.](#)
- [American Cancer Society. 2020 Guideline Update: Cervical cancer screening for individuals at average risk.](#)
- [American Society for Colposcopy and Cervical Pathology. 2019. Risk-based management consensus guidelines for abnormal cervical cancer screening tests and cancer precursors.](#)
- [USPSTF Final Recommendation Statement on Chlamydia and Gonorrhea: Screening \(2021\)](#)
- [Centers for Disease Control and Prevention *What Should I Know about Cervical Cancer Screening \(2021\)*](#)
- [USPSTF Final Recommendation Statement on PrEp](#)

References

1. [ACHA, 2020. Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings.](#)
2. [Centers for Disease Control and Prevention, 2021. STI Prevalence, Incidence, and Cost Estimates.](#)
3. [Centers for Disease Control and Prevention \(CDC\), 2021. Expedited Partner Therapy.](#)

Appendix: Response Tables

Section 1: Institutional Demographics and Visit Data

	Schools that provide Sexual Health Services		Schools that do NOT provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Public	76	59.4%	4	66.7%
Private	52	40.6%	2	33.3%
Total	128		6	

Type of Institution

	Schools that provide Sexual Health Services		Schools that do NOT provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
2-year	2	1.6%	2	33.3%
4-year	126	98.4%	4	66.7%
Total	128		6	

Institution Size

	Schools that provide Sexual Health Services		Schools that do NOT provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Less than 2,500	14	10.9%	1	16.7%
2,500-4,999	17	13.3%	2	33.3%
5,000-9,999	20	15.6%	3	50.0%
10,000-19,999	33	25.8%	0	0.0%
20,000 and above	44	34.4%	0	0.0%
Total	128		6	

Region per CDC/HHS

	Schools that provide Sexual Health Services		Schools that do NOT provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Northeast	41	32.0%	3	50.0%
Midwest	26	20.3%	2	33.3%
South	42	32.8%	1	16.7%
West	19	14.8%	0	0.0%
Total			6	

Campus Setting

	Schools that provide Sexual Health Services		Schools that do NOT provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Urban	75	58.6%	2	33.3%
Suburb	31	24.2%	1	16.7%
Town	22	17.2%	3	50.0%
Total	128		6	

Q6. Health center provides any clinical sexual health services

	Frequency	Percent
Yes	128	95.5%
No	6	4.5%
Total	134	100%

Q6A. Health center provides the following clinical sexual health services (select all that apply) (n=128 health centers)

	Frequency	Valid Percent*
Cervical cancer screening	109	85.2%
STI/HIV testing	120	93.8%
Pregnancy testing	126	98.4%
Contraception	118	92.2%
PrEP	82	64.1%
PEP	68	53.1%
HPV vaccinations	76	59.4%

*Sum is > 100% because respondents could select more than one response

Q6B. EHR products currently being used at health center (n=128)

	Frequency	Valid Percent*
Careflow	0	0.0%
Cerner	4	3.0%
GE Centricity	0	0.0%
E-ClinicalWorks	2	1.5%
EPIC	4	3.0%
Magnus Health	0	0.0%
Medicat	43	32.1%
NextGEN	1	0.7%
NueMD	0	0.0%
Point and Click Solutions	42	31.3%
Practice Fusion	0	0.0%
PyraMED	15	11.2%
Titanium	0	0.0%
None- we use paper only	1	0.7%
Other EHR product (please specify):	2	1.5%

*Respondents could select more than one response

Q6C1. Electronic medical record captures the following categories at your health center

	Frequency	Valid Percent
Assigned sex (n=124)	112	90.3%
Gender identity (n=123)	100	81.3%
Race/ethnicity (n=122)	108	88.5%
Sexual orientation (n=121)	63	52.1%

Q6C2. Health center has the ability to run reports based on the following categories

	Frequency	Valid Percent
Assigned sex (n=120)	97	80.8%
Gender identity (n=115)	69	60.0%
Race/ethnicity (n=117)	91	77.8%
Sexual orientation (n=113)	46	40.7%

Q6C3. Health center runs reports based on the following categories

	Frequency	Valid Percent
Assigned sex (n=118)	65	55.1%
Gender identity (n=116)	33	28.4%
Race/ethnicity (n=118)	58	49.2%
Sexual orientation (n=116)	19	16.4%

Q7. Health Center Visits (includes both in-person and telemedicine) (n=119)

	Total number of student medical visits to your health center in 2023	Number of virtual/telemedicine visits
Mean	13,106	1,052
Median	6,864	45
Minimum	30	0
Maximum	96,450	37,303
Sum	1,559,582	125,152

Section 2: Surveillance**Q8. CY 2023 Summary of all Pap test results**

	Frequency	Percent
Total # of Pap tests done (n=109)	18,478	
Normal (n=109)	15,802	85.5%
ASC-US (n=109)	1,282	6.9%
LSIL (n=109)	822	4.4%
ASC-H (n=109)	74	0.4%
HSIL (n=109)	32	0.2%
ACG or CIS (n=109)	22	0.1%
Unsatisfactory, no dx (n=109)	271	1.5%
other dx, not listed above (n=109)	173	0.9%
no endocervical cells (with any dx above) (n=73)	920	5.0%

Q9. CY 2023 Chlamydia testing

Out of 266,019 female patients under age 25 seen at 84 health centers, 43,157 were tested for chlamydia (16.2%).

Q10-Q13 CY 2023 STI/HIV Positivity

	Gonorrhea (n=108)	Chlamydia (n=109)	HIV (n=107)	Syphilis (n=107)
# tested	147,522	139,115	61,355	48,757
# positive	2,300	7,766	135	603
Positivity Rate (%)	1.56%	5.58%	0.22%	1.24%

Q10A. If known, how many of the positive Gonorrhea tests were from the following types of tests?

	Frequency	Percent
Urine test	583	31.0%
Anal swab	421	22.4%
Oral swab	690	36.7%
Urethral swab	2	0.1%
Vaginal swab	184	9.8%
Total	1,880	

Q11A. If known, how many of the positive Chlamydia tests were from the following types of tests?

	Frequency	Percent
Urine test	2,406	49.9%
Anal swab	510	10.6%
Oral swab	343	7.1%
Urethral swab	5	0.1%
Vaginal swab	1,558	32.3%
Total	4,822	

Q11B. Is EPT offered for chlamydia in your student health center?

	Frequency	Percent
Yes, required by clinic policy	6	5.1%
Yes, allowed by clinic policy and offered at provider discretion	75	63.6%
No, it is not legal in my state	3	2.5%
No, it is not allowed by clinic policy	13	11.0%
No, we do not have a provider to prescribe	1	0.8%
No – other reason(s)	18	15.3%
I don't know	2	1.7%
Total	118	

Q12A. If known, how many of the positive HIV tests were from the following types of tests?

	Frequency	Percent
Rapid oral	0	0.0%
Serum antibody	24	19.0%
Serum antigen	28	22.2%
Serum NAAT	1	0.8%
Other*	73	57.9%
Total	126	

*Other write-ins included antigen/antibody combination testing

Q14. CY 2023 Herpes Positivity

	HSV overall
# tested	5,267
# positive for HSV-2	451
# positive for HSV-1	1,080
# positive for type unknown	115
Total positive for any type	1,646 (31.3%)

14. CY 2023 Breakdown for all positive Herpes tests

	All patients
Positive for HSV-2	451 (27.4%)
Positive for HSV-1	1,080 (65.6%)
Positive for type unknown	115 (7.0%)
Total positive for any type	1,646

15. Number of patients diagnosed with trichomoniasis in 2023: 209 at 107 schools

16. Number of patients diagnosed with bacterial vaginosis in 2023: 9,326 at 100 schools

17. Number of patients diagnosed with genital warts in 2023: 415 at 89 schools

Section 3: Pregnancy Testing

18. CY 2023 Number of Pregnancy tests done (n=123)

	All patients
Number of Pregnancy tests done	33,239
Positive pregnancy tests	953
Positivity Rate (%)	2.9%